Department of Water and Power
Health and Dental Plans Administration
111 North Hope Street Room 564
Los Angeles CA 90012
Tel: (213) 367-2023 Fax: (213) 367-2078

ENROLLMENT/CHANGE FORM

RETIREE

EFFECTIVE DATE

1 TRANSACTION TYPE

☐ New Enrollment
☐ Addition/Deletion of Dependent
☐ Address Change
☐ Name Change
☐ Cancellation of Enrollment

If you wish to enroll in, change, or cancel an IBEW Local 18 sponsored plan you must contact IBEW Benefit Service Center at (800) 842 6635.

2A HEALTH PLANS

☐ Kaiser Permanente/Senior Advantage
☐ United Healthcare HMO/Group Medicare Advantage
☐ Health Plan of Nevada/Senior Dimensions
☐ United Healthcare PPO Option A
☐ United Healthcare PPO Option B
☐ United Healthcare PPO Option C

2B DENTAL PLANS

☐ United Concordia Preferred
☐ United Concordia Plus

3 SUBSCRIBER INFORMATION

Last Name	First Name	MI	Social Security No.	Employee No.

Daytime Phone No.	Home Address	City	State	ZIP Code

Birth Date	Sex	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Claim Number

4 DEPENDENTS TO BE ENROLLED

Last Name	First Name & MI	Birth Date	Social Security No.	Sex	Relationship	Provider No.

If you are enrolling a spouse over age 65 or has Medicare, please provide information:	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Claim Number

If enrolling a spouse please provide a copy of Marriage Certificate. If enrolling a Domestic Partner, provide copies of Drivers Licenses or ID showing same address and an Affidavit of Domestic Partnership

Date of Marriage or Start of Domestic Partnership: ____________

Please note a Social Security Number is required to verify eligibility of your dependents.

IMPORTANT:	If you and/or your spouse/domestic partner or dependent child has Medicare, you will need to fill out additional forms such as: Senior Advantage Election Form or United Healthcare Medicare Rx Form; or Secure Horizons or Senior Dimension if you have Medicare A & B

5 DEPENDENTS TO BE DELETED

Last Name	First Name & MI	Birth Date	Social Security No	Relationship	Reason for Deletion

Date of Divorce: ____________ Date of Death: ____________

Must provide a copy of final divorce decree

I hereby authorize DWP to deduct from my earnings, from time to time until further notice, amounts equal to the contributions required of me towards the plan(s) herein enrolled. I understand that if I decline coverage, I will not be able to enroll for health or dental coverage until the next Open Enrollment period, unless I have a change in status. I understand that all of my benefit choices shown here will be in effect until the next Open Enrollment unless there is a change in my status, my employment status or my spouses/domestic partner's employment status or loss of coverage. I understand that any dispute or controversy that may arise under the agreement between me and/or any family member and any Health Maintenance Organization named above, or any participating office, must be submitted to binding arbitration in lieu of a jury or court trial.

Retiree Signature:	Date:
Spouse Signature:	Date:

PLEASE READ INSTRUCTIONS AND IMPORTANT INFORMATION AT THE BACK